GENERAL INFORMATION

All claims submitted to AHCCCS by Indian Health Service (IHS) and tribal providers are extensively edited by the AHCCCS claims processing system.

The process begins with a check of the quality and completeness of the data entered on the claim. If required fields are not completed or if any fields are completed incorrectly, an error code will be identified for the claim. For example, if the date "March 10, 2004" should be recorded as 03/10/2004 (MM/DD/YYYY format) and the claim is received with 2004/03/10, the edit will create a failure for an invalid date.

The system also confirms that a provider ID, recipient ID, date(s) of service, place of service code (CMS 1500), diagnosis code(s), procedure/revenue/NDC code(s), and billed charges are present on the claim. These data elements, as applicable, are required on all claims.

After editing for completeness and correctness of the data submitted, the system edits to ensure that data fields are valid and logical. The most important of these edits assure that:

- ☑ Your provider ID number is on the provider record
- ☑ You have the authority to provide this service
- ☑ The recipient is on file, eligible, and entitled to the service
- ☑ The service was covered by AHCCCS on the date(s) it was delivered
- ☑ Diagnosis and procedure codes were valid for the date(s) of service

Another set of edits assures that the claim complies with AHCCCS policy requirements. These include:

- ☑ Prior authorization is obtained (if required)
- ☑ The claim is reviewed by AHCCCS medical staff before payment (if required)
- ☑ The service is allowed for the recipient's age and gender

The final step in the review of the claim is an audit process to assure that reimbursement for the service has not been previously paid or does not exceed service limitations. The claims system audits for duplicates, checking whether the recipient, provider, date(s) of service, and procedure/ diagnosis are the same on a paid claim and the claim being reviewed.

EDITING PROCESS

The claims system attempts to apply all edits during a single processing cycle. This enables AHCCCS to report all errors to you and avoid claims failing new edits after you have corrected and resubmitted the claim. However, if certain data are missing, incorrect, or invalid, completion of the entire processing cycle may not be possible.

When a claim fails an edit or an audit, an error record is created for that claim. All failed edits related to the claim denial are displayed in the denied claims section of your Remittance Advice with an edit number, decimal point, and a single digit that further defines the problem. A description of the edit code is listed on the Processing Notes page of the Remittance Advice. (See Chapter 18, Understanding the Remittance Advice)

Examples of edit codes:

H001.1 - Service Provider ID - Field Is Missing

H001.3 - Service Provider ID - Field Is Not On File

L023.1 -Diagnosis Code #1 – Invalid for Recipient Age & Gender

L023.2 -Diagnosis Code #1 – Invalid for Recipient Age

L023.3 -Diagnosis Code #1 – Invalid for Recipient Gender

If one or more edits is (are) failed during the editing process, there are two possible outcomes:

- ☑ The claim may stop processing and "pend" for internal review when the error detected concerns data or procedures that may be resolved by AHCCCS staff.
  - ✓ When a claim requires Medical Review, for example, it will pend internally until Medical Review screens the services being billed.
  - ✓ Internally pended claims are generally handled without input from providers.
    - ☒ The exception is when medical documentation is requested for a claim under review.
- ☑ The claim may be denied. (See Chapter 17, Correcting Claim Errors)
  - ✓ If the data required for adjudication of a claim is complete but the service does not meet AHCCCS policy requirements, the claim will be denied.
  - ✓ For example, if a provider was not registered or if a recipient was not eligible on the date of service, payment would be denied.

EDITING PROCESS (CONT.)

AHCCCS' intention is to process all clean claims in a timely manner, normally within 30 days. A claim is considered "clean" on the date the following conditions are met:

- ☑ All required information has been received by AHCCCS.
- ☑ The claim meets all AHCCCS submission requirements.
- ☑ The claim is legible enough to permit electronic image scanning.
- ☑ All errors in the data provided are corrected.
- ☑ All medical documentation required for medical review has been provided.

A *Claim Reference Number (CRN)* is assigned to all claims on initial submission to AHCCCS. The first five characters of the CRN represent the Julian date the claim was initially received by AHCCCS. The remaining numbers make up the claim document number assigned by AHCCCS. The CRN does not change regardless of the number of times the claim is resubmitted or adjusted.

When submitting documentation (e.g., Medicare EOB) subsequent to submission of a claim, you must provide the CRN of the claim to enable AHCCCS to link the documentation to the claim.

You also must provide the initial CRN when resubmitting, adjusting, or voiding a claim. If your claim is resubmitted without the CRN, the claim will be treated as a first-time submission and may not pass the 6- month initial claim filing deadline or the 12-month clean claim deadline. Your claim also may be denied as a duplicate of an existing claim.

PRICING OF CLAIMS

When the editing process is completed and no errors are found on the claim, it will proceed to pricing and payment.

AHCCCS' pricing methodologies include, but are not limited to:

- ☑ Ratios, such as inpatient and outpatient cost-to-charge ratios
- ☑ Percentages, such as a percentage of the capped fee for a service when performed by certain provider types, or when modifiers are used
- ☑ Set amounts, or capped fees, such as the unit price for ambulance mileage or the OMB rate for IHS/638 tribal facility outpatient services
- ☑ Per diem amounts, such as the OMB per diem rate for inpatient stays in an IHS/638 tribal facility.

PRICING OF CLAIMS (CONT.)

The AHCCCS claims processing system prices claims using the following pricing hierarchy:

1. AHCCCS reimburses the Medicare coinsurance, deductible, or co-pay, minus any third party payments, for Medicare-covered services for recipients with Medicare.
2. If the provider has negotiated a settlement with the AHCCCS Office of Legal Assistance, the claim is priced in accordance with the negotiated settlement.
3. If there is a provider-specific rate on file for the service, covered charges are priced at 100 per cent of billed charges or the provider-specific rate, whichever is less.
4. If there is no provider-specific rate for the service, the system determines if there is a capped fee on file for the procedure.

   If there is a capped fee for the service, covered charges are priced at 100 per cent of the billed charges or the capped fee for service, whichever is less.

   AHCCCS had adopted a facility/non-facility rate differential similar to the Medicare format. The facility/non-facility rate structure assigns a reimbursement rate for a given AHCCCS-covered procedure code based on the billed place of service (POS) code.

   The OMB rate for IHS/638 tribal facility outpatient services is considered to be a capped fee.
5. If there is no provider-specific rate for the service, no capped fee on file, and the service does not require manual pricing, the system determines if a specific rate has been prior authorized.

   If there is a prior authorized rate on file for the provider, recipient, date of service, and service being billed, the claim is priced at 100 per cent of covered billed charges or the prior authorized amount, whichever is less.
6. If none of the above pricing methodologies have been applied at this point, claims billed on a CMS 1500 claim form (837P for electronic claims) are reimbursed at 65 per cent of covered billed charges. Claims billed on a UB-92 claim form (837I for electronic claims) are reimbursed at 80 per cent of covered billed charges